A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals
A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals

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Chapter 1  An Overview for Providers Treating LGBT Clients

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What providers will learn from this chapter:

• The epidemiology of substance abuse among the LGBT population
• The types of substances abused
• Definitions of key terms
• Characteristics of LGBT individuals
• How differences in LGBT life experiences may shape the substance abuse issues
• Life cycle issues for LGBT individuals

Introduction

For substance abuse treatment providers to deliver skilled care to lesbian, gay, bisexual, and transgender (LGBT) clients, they need to be aware of issues specific to the LGBT community. This chapter presents an overview of the use and abuse of substances in the LGBT community and a brief introduction to the concepts of gender identity, sexual orientation, homophobia, and heterosexism.

Substance Use and Abuse in the LGBT Community

In a discussion of the epidemiology of substance use and abuse among LGBT individuals, the following two questions are of interest to providers:

• What is the epidemiology of substance use and abuse among LGBT individuals?

• Do LGBT individuals use or abuse more substances than heterosexuals or the general population?

Epidemiology is the study of the patterns of disease and health problems in populations and the factors that influence these patterns. Prevalence refers to the number of people in a given population who are affected by a particular disease at a certain time; it is frequently expressed in percentages. Incidence refers to the number of new
cases of a disease or condition, such as alcoholism or drug abuse, in a given population over a specified time (such as a year).

Rates of substance use and abuse vary from population to population. The numerous reasons for the varying rates include biological, genetic, psychological, familial, religious, cultural, and historical circumstances. The LGBT population is similar to the general population in that numerous factors predispose its members to substance abuse. However, some clinicians argue that the additional stigma and resulting tension of being a member of a marginalized community such as the LGBT community cause some members of the marginalized community to seek to manage these additional stressors by using mind-altering substances.

The precise incidence and prevalence rates of substance use and abuse by LGBT individuals have been difficult to determine for several reasons. Reliable information on the size of the LGBT population is not available. Scientific studies of LGBT individuals’ substance abuse do not always clearly define the difference between substance use and substance abuse, making it difficult to compare studies. Many studies have methodological flaws, such as the use of convenience samples that only infer or estimate substance abuse among the LGBT population. However, several promising studies are under way that, it is hoped, will provide additional information. The Substance Abuse and Mental Health Services Administration’s (SAMHSA’s) Center for Substance Abuse Treatment (CSAT) will continue to report the results of these studies as they are completed.

To provide background information for this publication, the authors conducted a review of the epidemiological literature, and 16 studies were chosen to highlight the extent of substance use or abuse problems in the LGBT population. The table in appendix D, Studies on LGBT Substance Abuse, presents a comparison of the studies. Studies were included if they focused on the LGBT population and substance abuse but did not focus primarily on the human immunodeficiency virus (HIV). These studies are considered classics and have been cited in numerous articles about LGBT individuals’ substance abuse. The summary is by no means exhaustive; however, it provides the context for exploring the issue and has implications for future research.

Publication dates of articles about the selected studies range from 1970 to 2000. Of the 16 studies, 10 focused primarily on substance abuse in the lesbian population, 3 focused on both lesbians and gay men, 1 focused exclusively on gay men, 1 focused exclusively on men who have sex with men (MSM), and 1 focused on transgender individuals. Eleven of the studies used convenience samples, and five used population-based data. Most of the studies reported on alcohol use.

These studies generally state that gay men and lesbians have greater substance abuse problems than non-LGBT men and women. In seven studies, comparisons between the LGBT population and the heterosexual population could not be made. Studies by Saghir and colleagues (1970); Fifield, DeCrescenzo, and Latham (1975); Lewis, Saghir, and Robins (1982); and Morales and Graves (1983) found that approximately 30 percent of all lesbians have an alcohol abuse problem. Studies that compared gay men or lesbians with heterosexuals (Stall & Wiley, 1988; McKirnan & Peterson, 1989; Bloomfield, 1993; Skinner, 1994; Skinner & Otis, 1996; Hughes & Wilsnack, 1997) found that gay men and lesbians were heavier substance and alcohol users than the general or heterosexual population. From these studies, it is clear that substance abuse treatment is needed and that providers need to know more about this community to provide competent treatment.
Types of Substances Abused

Over the past several years, the concerns about the epidemic of HIV-related conditions have led to an increased number of studies of both gay and bisexual men and injection drug users. Although LGBT persons use and abuse alcohol and all types of drugs, certain drugs seem to be more popular in the LGBT community than in the majority community.

Woody and colleagues (1999) compared a convenience sample of MSM at high risk for HIV who participated in a vaccine preparedness study with a nationally representative sample of men from the 1995 National Household Survey on Drug Abuse (NHSDA). The study found that these MSM were 21 times more likely to use nitrite inhalants. They were also much more likely (four to seven times) to use hallucinogens, stimulants, sedatives, and tranquilizers than the men in the NHSDA sample. The study also found that weekly use by this MSM sample was 2 times more likely for marijuana, cocaine, and stimulants and 33 times more likely for inhalant nitrites.

A study by Cochran and Mays (2000) found that people with same-sex partners were more likely to use substances than were people with opposite-sex partners. Closer examination of the data (Cochran et al., in press) comparing MSM with heterosexual men and comparing lesbians with heterosexual women showed little difference between MSM and heterosexual male substance abuse but showed that rates of alcohol use were much higher for lesbians than for heterosexual women. For example, lesbians used alcohol twice as often in the past month, were five times more likely to use alcohol every day, were more than twice as likely to get intoxicated, and were four times more likely to get intoxicated weekly than heterosexual women.

Another study of lesbians using self-reported data stated that rates of alcohol use in the lesbian population were higher than those in the general population, but not as high as rates in other studies, and that the most significant predictor of alcohol use was reliance on bars as a primary social setting (Heffernan, 1998).

Designer Drug Use

Abuse of methamphetamine, also known as meth, speed, crystal, or crank, has increased dramatically in recent years (Drug Abuse Warning Network, 1998; Derlet & Heischober, 1990; Morgan et al., 1993; National Institute on Drug Abuse, 1994; Gorman, Morgan & Lambert, 1995; CSAT, 1997b), particularly among gay men but also among male-to-female (MTF) transgender individuals and, increasingly, among some groups of lesbians. What makes the current epidemic so disconcerting is its relationship to the HIV epidemic (Ostrow, 1996; Gorman et al., 1997).

Amphetamines and methamphetamine currently are the most popular synthetic stimulants in the United States, and abuse of them can lead to significant dependence and addiction. The drugs may be drunk, eaten, smoked, injected, or absorbed rectally. They have a half-life of approximately 24 hours. They work by releasing neurotransmitters, and users suffer the same addiction cycle and withdrawal reactions as those suffered by crack cocaine users. These substances increase the heart rate, blood pressure, respiration rate, and body temperature. They cause pupil dilation and produce alertness, a sense of euphoria, and increased energy. After prolonged use, users often experience severe depression and sometimes paranoia. They may also become belligerent and aggressive.

Methamphetamine use appears to be integral to the sexual activities of a certain segment of gay men, especially in some urban communities. The so-called party drugs, such as MDMA (methyleneoxymethamphetamine) (also known as ecstasy or X-T-C), “Special K” or
ketamine, and GHB (gamma hydroxybutyrate), are increasingly popular at dances and celebrations, such as circuit parties and raves.

MDMA is a synthetic drug with hallucinogenic and amphetamine-like properties. The effects are reminiscent of lysergic acid diethylamide-25 (LSD). Ketamine, a white crystalline powder that is soluble in water and alcohol, is a dissociative anesthetic, a synthetic drug that produces hallucinations, analgesia, and amnesia and can cause euphoria. Users can experience impaired thought processes, confusion, dizziness, impaired motor coordination, and slurred speech. Liquid X (GHB) possesses euphoric properties, and overdoses can cause electrolyte imbalances, decreased respiration, confusion, and hypertension, as well as seizure-like activity and vomiting.

Party drugs can impair judgment and increase sexual risk taking. Research has shown a connection between use of nitrite and high-risk sexual behavior (Ostrow et al., 1993), and there is compelling evidence that HIV and hepatitis C infections are linked with methamphetamine use. Studies in several cities indicate that gay and bisexual men who used speed, alone or in combination with other drugs, appear to have much higher seroprevalence rates than either heterosexual injection drug users or gay and bisexual men who do not use these drugs (Harris et al., 1993; Diaz et al., 1994; Gorman, 1996; CDC [Centers for Disease Control and Prevention], 1995; Hays, Kegeles & Coates, 1990; Waldorf & Murphy, 1990; Paul, Stall & Davis, 1993; Paul et al., 1994). This finding is particularly apparent for individuals who inject these drugs and who share needles or injecting equipment. Although most LGBT meth users probably snort, ingest, or smoke the drugs, a sizable number also report histories of injection drug use. Within the substance-abusing population in general, and the LGBT population in particular, injection drug users represent an often hidden and stigmatized group. Public health efforts have targeted mostly heterosexual injection drug users of heroin. A number of injection drug users inject methamphetamine, and a number of these are LGBT individuals.

Information on the needle hygiene of methamphetamine users or LGBT injection drug users is lacking. Some HIV-positive individuals appear to be self-medicating for depression or specific HIV-related symptoms by using methamphetamine because it reduces lethargy, raises libido, and can be an antidepressant. Mixing these drugs can be dangerous, and some deaths have been documented from using party drugs while taking protease inhibitors.

Definition of Terms and Concepts Related to LGBT Issues

Understanding how certain terms are used is essential to understanding homophobia. It is important to recognize the difference between sexual orientation and sexual behavior as well as the differences among sexual orientation, gender identity, and gender role.

Sexual orientation may be defined as the erotic and affectional (or loving) attraction to another person, including erotic fantasy, erotic activity or behavior, and affectional needs. Heterosexuality is the attraction to persons of the opposite sex; homosexuality, to persons of the same sex; and bisexuality, to both sexes. Sexual orientation can be seen as part of a continuum ranging from same-sex attraction only (at one end of the continuum) to opposite-sex attraction only (at the other end of the continuum).

Sexual behavior, or sexual activity, differs from sexual orientation and alone does not define someone as an LGBT individual. Any person may be capable of sexual behavior with a person of the same or opposite sex, but an individual knows his or her longings—erotic
and affectional—and which sex is more likely to satisfy those needs.

It is necessary to draw a distinction between sexual orientation and sexual behavior. Not every person with a homosexual or bisexual orientation, as indicated by his or her fantasies, engages in homosexual behavior. Nor does sexual behavior alone define orientation. A personal awareness of having a sexual orientation that is not exclusively heterosexual is one way a person identifies herself or himself as an LGBT person. Or a person may have a sexual identity that differs from his or her biological sex—that is, a person may have been born a male but identifies and feels more comfortable as a female. Sexual orientation and gender identity are two independent variables in an individual’s definition of himself or herself.

**Sexual identity** is the personal and unique way that a person perceives his or her own sexual desires and sexual expressions. Biological sex is the biological distinction between men and women.

**Gender** is the concept of maleness and masculinity or femaleness and femininity. One’s **gender identity** is the sense of one’s self as male or female and does not refer to one’s sexual orientation or gender role. **Gender role** refers to the behaviors and desires to act in certain ways that are viewed as masculine or feminine by a particular culture.

A culture usually labels behaviors as masculine or feminine, but these behaviors are not necessarily a direct component of gender or gender identity. It is common in our culture to call the behaviors, styles, or interests shown by males that are usually associated with women “effeminate” and to call the boys who behave this way “sissies.” Women or girls who have interests usually associated with men are labeled “masculine” or “butch,” and the girls are often called “tomboys.”

**Transgender** individuals are those who conform to the gender role expectations of the opposite sex or those who may clearly identify their gender as the opposite of their biological sex. In common usage, transgender usually refers to people in the transsexual group that may include people who are contemplating or preparing for sexual reassignment surgery—called preoperative—or who have undergone sexual reassignment surgery—called postoperative. A transgender person may be sexually attracted to males, females, or both.

**Transvestites** cross dress, that is, wear clothes usually worn by people of the opposite biological sex. They do not, however, identify themselves as having a gender identity different from their biological sex or gender role. The motivations for cross dressing vary, but most transvestites enjoy cross dressing and may experience sexual excitement from it. The vast majority of transvestites are heterosexual, and they usually are not included in general discussions about LGBT people.

**Gender identity disorder** (GID) was introduced in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV) (American Psychiatric Association, 1994). Although GID is listed as a mental illness, most clinicians do not consider individuals who are confused or conflicted about their biological gender and their personal sense of their gender identity to be mentally ill. Considerable work needs to be done to augment the small amount of research available on the development of a transgender identity—that is, how a person becomes aware of a sexual identity that does not match his or her biological sex or gender role.

**Estimates of the Number of LGBT Individuals**

The true number of people who identify themselves as LGBT individuals is not known. Because of a lack of research focusing on the
LGBT population and the mistrust that makes many LGBT people afraid to be open about their identity, reliable data are difficult to obtain. The popular estimate that 10 percent of the male population and 5 to 6 percent of the female population are exclusively or predominately homosexual is based on the Kinsey Institute data (Kinsey, Pomeran & Martin, 1948; Kinsey et al., 1953) addressing sexual behavior. Kinsey proposed the Kinsey Scale, a continuum that rated sexual behavior on a scale from zero to six. Zero represented exclusive heterosexual behavior and six represented exclusive homosexual behavior. The survey reported that 37 percent of American men had at least one homosexual experience after adolescence; 5 to 7 percent had bisexual experiences but preferred homosexual ones; and 4 to 5 percent had homosexual experiences exclusively.

These data illustrate how widespread male homosexual behavior is, not necessarily the number of gay men. The same research indicated that the majority of those surveyed reported behavior in a range Kinsey termed bisexual. Again, the classification is based only on reported behavior. For many minority populations, bisexuality—but not homosexuality—is acceptable (or at least admissible on surveys). For example, in the 1989 Centers for Disease Control and Prevention 8-year review of acquired immunodeficiency syndrome (AIDS) cases among gay or bisexual men, 54.2 percent of African Americans were reported to be bisexual, 44.2 percent of Hispanics were reported to be bisexual, and 11.3 percent of Caucasians were reported to be bisexual.

Michaels (1996) thoroughly analyzed the limited available data and concluded that determining prevalence rates of sexual orientations is extremely difficult because the data are widely disparate. He estimates that in the United States, 9.8 percent of men and 5 percent of women report same-gender sexual behavior since puberty; 7.7 percent of men and 7.5 percent of women report same-gender desire; and 2.8 percent of men and 1.4 percent of women report a homosexual or bisexual identity.

The data on the number of transgender people are even more limited. Some psychiatric literature estimates that 1 percent of the population may have had a transgender experience, but this estimate is based only on transgender people who might have sought mental health services (Seil, 1996).

**Homophobia and Heterosexism**

Having a general understanding of heterosexism, homophobia, and antigay bias is important for substance abuse treatment providers working with LGBT individuals. Alport (1952) defined prejudice as a negative attitude based on error and overgeneralization and identified the three interdependent states of acting out prejudice as verbal attacks, discrimination, and violence. Verbal attacks can range from denigratory language to pseudoscientific theories and findings, which serve as a foundation for discrimination and violence. Following this theory, prejudice and discrimination against LGBT individuals is formed, in part, by misinformation such as the following:

- All gay men are effeminate, and all lesbians are masculine.
- LGBT persons are child molesters.
- LGBT individuals are unsuitable for professional responsibilities and positions.
- LGBT persons cannot have fulfilling relationships.
- LGBT persons are mentally ill.

Once negative generalizations are formed about a group of people, some members of the majority group feel that they can treat the
other group differently. As the acceptance of negative stereotypes spreads, discrimination and violence can result.

Heterosexism and homophobia are used to describe the prejudice against LGBT people. **Heterosexism** is a prejudice similar to racism and sexism. It denies, ignores, denigrates, or stigmatizes any nonheterosexual form of emotional and affectional expression, sexual activity, behavior, relationship, or socially identified community. Heterosexism exists in everyone—LGBT individuals as well as heterosexuals—because almost everyone is brought up in a predominately heterosexual society that has little or no positive recognition of homosexuality or bisexuality. Heterosexism supports the mistaken belief that gay men—because they are attracted to men—are in some way like women, and lesbians, in turn, are in some way like men.

**Homophobia**, although a popular term, lacks precise meaning. Coined in 1972 to describe fear and loathing of gay men and lesbians, it also has been used by gay men, lesbians, and bisexuals to describe self-loathing, fear, or resistance to accepting and expressing sexual orientation (Weinberg, 1983). **Antigay bias** is another phrase to describe the first concept, and **internalized homophobia** is another phrase for the latter. Internalized homophobia is a key concept in understanding issues facing gay men, lesbians, and bisexuals in substance abuse treatment.

Examples of heterosexism in the United States include the following:

- The widespread lack of legal protection for individuals in employment and housing
- The continuing ban on lesbian and gay military personnel
- The hostility and lack of support for lesbian and gay committed relationships (except in Vermont) as seen in the passage of Federal and State laws against same-gender marriages
- The enforcement of outdated sodomy laws that are applied to LGBT individuals but not applied to heterosexual individuals.

Examples of heterosexism in the substance abuse treatment setting are as follows:

- Gay-bashing conversations
- Cynical remarks and jokes regarding gay sexual behaviors
- Jokes about openly LGBT staff members
- Lack of openly LGBT personnel
- Lack of inclusion of LGBT individuals’ family members or significant others in treatment processes.

Substance abuse treatment providers should remember that LGBT clients do not know the reaction they will receive when mentioning their sexual orientation. For example, public opinion measures indicate that homosexuality is not widely accepted. In 1996, Gallup Poll data showed 50 percent of respondents reported that homosexuality was unacceptable and only 45 percent found homosexuality an acceptable lifestyle. In addition, Herek (1989) found that as many as 92 percent of lesbians and gay men reported that they have been the target of threats, and as many as 24 percent reported physical attacks because of their sexual orientation.

It is likely that all substance abuse treatment programs have LGBT clients, but staff members may not be aware that they are treating LGBT clients. Most treatment programs do not ask about sexual orientation, and many LGBT people are afraid to speak openly about their sexual orientation or identity. Treatment
programs also may not realize that they have LGBT staff members, who can be a great resource for treating LGBT clients.

How Heterosexism Contributes to Substance Abuse

When treating LGBT clients, it is helpful for providers to understand the effect of heterosexism on their LGBT clients. The role of heterosexism in the etiology of substance abuse is unclear. Heterosexism instills shame in LGBT individuals, causing them to internalize the homophobia that is directed toward them by society (Neisen, 1990, 1993). Some LGBT individuals may use intoxicants to cope with shame and other negative feelings. Some LGBT individuals learn to devalue themselves and value only heterosexual persons instead. The negative effects of heterosexism include the following:

- Self-blame for the victimization one has suffered
- A negative self-concept as a result of negative messages about homosexuality
- Anger directed inward resulting in destructive patterns such as substance abuse
- A victim mentality or feelings of inadequacy, hopelessness, and despair that interfere with leading a fulfilling life
- Self-victimization that may hinder emotional growth and development.

Recognizing that heterosexism is a type of victimization helps the counselor and client draw a parallel with recovery from other types of victimization, whether they are culturally or individually based. It is crucial that counselors and clients recognize that these effects result from prejudice and discrimination and are not a consequence of one’s sexuality. It is not surprising to find that many LGBT individuals in therapy report feeling isolated, fearful, depressed, anxious, and angry and have difficulty trusting others. Meyer (1993) reports that the victimization of gay males in our society results in mental health consequences for individuals. A skilled substance abuse treatment counselor should be attentive to the negative effects that prejudice produces when working with LGBT clients.

Perspectives on Homosexuality

Homosexuality, as a specific category, was not described in the medical or psychiatric literature until the early 1870s. The fledgling psychoanalytic movement regarded homosexuality as a topic of special interest. Sigmund Freud believed a person’s sexual orientation, in and of itself, did not impair his or her judgment or cause problems, and Freud set a positive tone when he supported homosexual colleagues in medical and psychiatric societies. Even so, European psychoanalytic organizations did not welcome gay men and lesbians as members in the early years of psychiatry, and many American psychiatrists and psychoanalysts promoted the attitude that homosexuality was a mental disorder.

Bieber and colleagues (1962) proposed that childhood influences and family upbringing were responsible for producing male homosexuality and described the classic combination of a distant, uninvolved father and an overinvolved mother. They did not consider biology or genetics as playing a role. Other psychoanalytic writing also refuted a biological component to female homosexuality, seeing it as caused primarily by early developmental disturbances.

Alfred Kinsey introduced new perspectives on homosexuality with his studies of sexual behavior (Kinsey, Pomeroy & Martin, 1948; Kinsey et al., 1953). Although his studies have been criticized for a variety of reasons, such as poor sampling methods, the studies greatly
increased Americans’ awareness of sexuality and the range of sexual behavior.

The psychologist Evelyn Hooker (1957) demonstrated that no discernible differences existed between the psychological profiles of gay men and those of heterosexual men, effectively beginning the debunking of the theory that homosexuality is a mental illness. Psychiatrist Judd Marmor (1980) recognized that homosexuality could not be explained in a single dimension and helped support exploring the biological, genetic, psychological, familial, and social factors involved in the formation and expression of a homosexual orientation.

In 1973, the American Psychiatric Association, after extensive scientific review and debate, stopped classifying homosexuality as a mental illness. Homosexuality is now seen as a normal variation of human sexual and emotional expression, allowing, it is hoped, a non-pathological and non-prejudicial view of homosexuality as well as of LGBT people. LGBT people and homosexual and bisexual behavior are found in almost all societies and cultures in the world and throughout history (Herdt, 1996). But the degree of tolerance and acceptance of them has varied considerably in different periods of history and from country to country, culture to culture, and community to community. Anthropological studies that have observed homosexual behavior in other cultures may help put homosexuality in global perspective and may contribute to understanding some of the issues facing American LGBT individuals who are from ethnic or cultural minority groups, such as African Americans (Jones & Hill, 1996), Asian Americans (Nakajima, Chan & Lee, 1996), Latinos/Latinas/Hispanics (Gonzalez & Espin, 1996), and Native Americans (Tafoya, 1996).

The genetic and biological contributions to sexual orientation have been studied increasingly in recent years. Unfortunately, the biological studies often grow out of the confusion between sexual orientation and gender identity. Many studies have tried to demonstrate that physical traits in gay men resemble those of women or have tried to identify traits in lesbians that resemble those of males. These views are based on the belief that, if a man wishes to be with a man, he must somehow be like a woman, and a woman wishing to be with a woman must, in some way, be like a man.

The Kinsey Institute has supported surveys and studies of both sexual behavior and sexual orientation and concluded that homosexuality must be innate, that is, inborn, and is not influenced developmentally by family upbringing (Bell & Weinberg, 1978; Bell, Weinberg & Hammersmith, 1981; Weinberg & Williams, 1974). The studies noted the diversity and variety of gay men and lesbians, recognizing that there was no uniform way to be or become gay or lesbian in our society.

Lesbianism and female homosexuality have also been studied from a non-pathological perspective. Magee and Miller (1998) reviewed these efforts and found no psychodynamic etiologies to female homosexuality and that each lesbian is unique and without stereotypic characteristics.

Studies of intersexual people, that is, people with sexually ambiguous genitalia or true hermaphrodites, are often analyzed. Hermaphrodites have both male and female reproductive organs. These studies ultimately are about gender role expectations and do not contribute to our understanding of homosexuality.

The most promising areas of study involve genetics and familial patterns. Although the gene has not been identified, Hamer and Copeland (1994) have reported a linkage on the X chromosome that may influence homosexual orientation. The genetic and familial patterns studied by Pillard, Bailey, and Weinrich and their colleagues (Bailey et
al., 1993; Bailey & Pillard, 1991; Pillard, 1996) have demonstrated the most consistent and verifiable data. Pillard found that gay men are much more likely to have gay or bisexual male siblings than heterosexual males—based on the incidence of homosexuality—but are not more likely to have lesbian sisters than are heterosexual males. Lesbians are more likely to have lesbian sisters but are not more likely to have gay brothers.

Combined with other twin and heritability studies, this research helps explain the probable genetic substrate of sexual orientation, with different genetic influences for male homosexuality, male heterosexuality, female homosexuality, female heterosexuality, and, possibly, bisexuality. Although the complex set of behaviors and feelings of homosexuality could not be explained by a single factor, a genetic basis seems to be the foundation on which other complex biological, familial, and societal influences work to shape the development and expression of sexual orientation (LeVay, 1996).

**Perspectives on Bisexuality**

Bisexuality has also existed throughout recorded history. Freud believed in innate bisexuality and that an individual evolves into a heterosexual or a homosexual, rarely a bisexual (Freud, 1963). Many bisexuals still find themselves contending with this lack of acknowledgment that a bisexual orientation can be an endpoint in itself and not just a step toward heterosexuality or homosexuality.

It is helpful for providers to know that the clinical issues facing bisexuals often are problems resulting from the difficulty of acknowledging and acting on a sexual orientation that is not accepted by the heterosexual majority but also not accepted by many gay men and lesbians.

Some people of color in the United States or people from different cultures may define themselves as bisexual, even if they focus exclusively on people of the same sex (Gonzalez & Espin, 1996). This perspective may be their way of coping with the stigma of homosexuality. Reviews that discuss theory and clinical issues include those by Weinberg, Williams, and Pryor (1994); Klein and Wolfe (1985); and Fox (1996).

**Sexual Orientation Over Time**

Although this chapter presents sexual orientation as belonging to one of three categories—homosexual, bisexual, or heterosexual—clearly sexual feelings, sexual behaviors, and sexual orientation may vary over time. As Kinsey found, sexual behavior ranges over a continuum from sexual activity with people of the same sex exclusively to sexual activity with people of the opposite sex exclusively, and most people’s behavior falls somewhere in between. Sexual orientation also follows the same continuum—from sexual interest in people of the same sex exclusively to sexual interest in people of the opposite sex exclusively.

The mapping of sexual orientation over time has not been well studied. It seems that most people have a fairly stable and fixed sexual orientation, once they become aware of their sexual orientation. Nevertheless, some people’s sexual orientation may vary. Women’s orientation may be more changeable than men’s, possibly because of society’s homophobia and because men are more uncomfortable with a nonheterosexual identity. Some people may not become fully aware of their orientation for years and may seem to change sexual orientation when, in fact, they are just becoming conscious of their true orientation. This knowledge may help providers support their LGBT client whose confusion about sexual issues is interfering with recovery from substance abuse.
Some types of therapies claim to be able to change a person’s sexual orientation. These conversion therapies or reparative therapies are often practiced by religiously based therapists or by some psychoanalysts who still consider homosexuality a mental illness. These therapies treat people who are uncomfortable with being gay, lesbian, or bisexual and—rather than helping an individual become comfortable with his or her inborn and natural sexual orientation—make the individuals even more uncomfortable and ashamed about being different. These attempts to change orientation may result in a temporary change of behavior. A gay man may stop having sex with other men or have sex with women, but his actual sexual orientation, expressed in his sexual fantasies, desires, or thoughts, possibly will not change. Almost all major mental health and medical organizations have condemned these therapies as ineffective and potentially harmful because they make the person feel guilty and ashamed (Haldeman, 1994).

Assessing Sexual Orientation

If a substance abuse treatment provider is concerned that a client is confused about his or her sexual orientation, some evaluation tools are available to help assess a client’s feelings. Coleman (1987) devised a relatively simple assessment tool to help map out or identify the sexual orientation of clients (see exhibit 1–1). The questionnaire considers the combination of sexual behavior, fantasies, feelings, and self-identification that contributes to sexual orientation. This tool may be a useful way to introduce a discussion about sexual orientation with clients who are uncomfortable with the topic. It may also help people understand the complexity of sexual expression and their comfort level with it. However, providers should be sensitive to the individual situation of the client in both administering and interpreting the instrument.

Life Cycle Issues

LGBT individuals face many of the same issues all people face as they progress through life. However, LGBT youth may have an especially difficult time. During adolescence, teens are under pressure to conform, and extraordinary effort and courage may be required for an LGBT teenager to “come out” to peers and family. Gay and lesbian youth may be subject to sexual abuse or exploitation sometimes related to their insecurity and low self-esteem. LGBT youth may face significant stress in coping with the attitudes of peers, teachers, and parents.

Older adolescent and young adult LGBT people focus on identity development through school, career choices, and sexual exploration and relations. Their social life often revolves around bars or other settings that promote drug and alcohol use (D’Augelli, 1996). When LGBT adolescents come out to their family, the result can range from understanding and support to verbal and physical abuse. Some youth run away from home and live on the streets (Savin-Williams, 1994).

Many LGBT people consider becoming part of a couple an important part of life. Although there are no legal sanctions for such relationships, except in Vermont, the majority of gay people are in relationships, and many are as committed as traditional heterosexual couples (Klinger & Cabaj, 1993). Some LGBT people are parents; they have had or adopted children (Patterson, 1995). LGBT clients belong to a family of origin. Depending on the circumstances, the relationship may be healthy or strained. Some LGBT people create their own family of choice consisting of a close network of friends that serves the needs often met by traditional families. Treatment providers need to consider an LGBT client’s partner, children, family of origin, and family of choice when providing care.
Exhibit 1–1:
Coleman’s Assessment Tool

Assessment of Sexual Orientation
© Eli Coleman, Ph.D.
1986

Name or Code Number: ___________________________ Age: __________ Date: __________

What is your current relationship status:
(check one box only)

☐ Single, no sexual partners
☐ Single, one committed partner—Duration:
☐ Single, multiple partners
☐ Coupled, living together (Committed to an exclusive sexual relationship)
☐ Coupled, living together (Relationship permits other partners under certain circumstances)
☐ Coupled, living apart (Committed to an exclusive sexual relationship)
☐ Coupled, living apart (Relationship permits other partners under certain circumstances)
☐ Other

In terms of my sexual orientation, I identify myself as. . .
(check one box only)

☐ Exclusively homosexual
☐ Predominantly homosexual
☐ Bisexual
☐ Predominantly heterosexual
☐ Exclusively heterosexual
☐ Unsure

In terms of my comfort with my current sexual orientation, I would say that I am. . .
(check one box only)

☐ Very comfortable
☐ Mostly comfortable
☐ Comfortable
☐ Not very comfortable
☐ Very uncomfortable

In the future, I would like to identify myself as. . .
(check one box only)

☐ Exclusively homosexual
☐ Predominantly homosexual
☐ Bisexual
☐ Predominantly heterosexual
☐ Exclusively heterosexual
☐ Unsure

Source: Coleman, 1987
Exhibit 1–1: Coleman’s Assessment Tool (continued)

INSTRUCTIONS:
Fill in the following circles by drawing lines to indicate which portion describes male or female elements. Indicate which portion of the circle is male by indicating (M) or female by indicating (F).

Example:  

If the entire circle is male or female, simply indicate the appropriate symbol in the circle (M or F).

Example:  

Fill in the circles indicating how it has been up to the present time as well as how you would like to see yourself in the future (ideal).

<table>
<thead>
<tr>
<th>UP TO THE PRESENT TIME</th>
<th>FUTURE (IDEAL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Identity</td>
<td>Physical Identity</td>
</tr>
<tr>
<td>I was born a biological. . .</td>
<td>Ideally, I wish I had been born as a biological. . .</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>Gender Identity</td>
</tr>
<tr>
<td>I think of myself as physically. . .</td>
<td>Ideally, I would like to think of myself as physically. . .</td>
</tr>
<tr>
<td>In my sexual fantasies, I imagine myself as physically. . .</td>
<td>In my sexual fantasies, I imagine myself as physically. . .</td>
</tr>
<tr>
<td>Sex-Role Identity</td>
<td>Sex-Role Identity</td>
</tr>
<tr>
<td>My interests, attitudes, appearance, and behaviors would be considered female or male (as traditionally defined). . .</td>
<td>I wish my interests, attitudes, appearance, and behaviors would be considered female or male (as traditionally defined). . .</td>
</tr>
<tr>
<td>Sexual Orientation Identity</td>
<td>Sexual Orientation Identity</td>
</tr>
<tr>
<td>My sexual activity has been with. . .</td>
<td>I wish my sexual activity would be with. . .</td>
</tr>
<tr>
<td>My sexual fantasies have been with. . .</td>
<td>I wish my sexual fantasies would be with. . .</td>
</tr>
<tr>
<td>My emotional attachments (not necessarily sexual) have been with. . .</td>
<td>I wish my emotional attachments (not necessarily sexual) would be with. . .</td>
</tr>
</tbody>
</table>
Older LGBT individuals may experience a sense of loss related to the aging process and associated changes in their physical attractiveness and capacities. This state may be further compounded by the lack of a partner or a legally sanctioned relationship. Consequently, their sense of a purpose and a future may become hazy and may be expressed in emotional and substance abuse problems (Kertzner & Sved, 1996).

Older LGBT people face the same concerns as other older persons regarding living arrangements and loss of loved ones and social supports. These concerns may be exacerbated for some LGBT people by HIV-related losses and limited familial support, that is, not having children and being isolated from their family of origin. Some people in this age group may need treatment for substance abuse or emotional issues avoided or ignored over the years (Berger & Kelly, 1996).

Summary

It is hoped that the information in this chapter helps providers improve their ability to provide competent and effective treatment. Treatment can be enhanced by a substance abuse treatment provider who is knowledgeable about the unique needs of LGBT clients. A provider who understands and is sensitive to the issues surrounding sexual and gender identity, homophobia, and heterosexism can help LGBT clients feel comfortable and safe while they confront their substance abuse and start their journey of recovery.
SECTION IV: APPENDIXES
The following terms are meant to guide the reader by providing clarity. However, it should be noted that some of the definitions continue to evolve over time as language changes from generation to generation.

**Acculturation**—Accommodation to the rules and expectations of the majority culture without giving up cultural identity entirely.

**Ageism**—Discriminatory behavior relating to age.

**Assimilation**—Adaptation to a new culture by taking on a new identity and abandoning the old cultural identity.

**Biphobia**—Irrational fear and dislike of bisexuals.

**Bisexual**—Man and woman with a sexual and affectional orientation toward people of both genders.

**Circuit Party**—Weekend dance party usually attended by urban gay males. These parties typically occur on a holiday weekend, and just as with many dance clubs and bars, many of their patrons are involved in substance use and abuse.

**Coming Out**—Individual and personal process by which a person accepts his or her homosexual or bisexual orientation and transforms it from a negative to a positive thing in a culture that is homophobic and does not validate and affirm diversity and difference. It is a process of healing from homophobia and heterosexism and taking on a positive identity. It may include sharing this process and its outcome with others or it may be private.

**Confidentiality**—Restriction against disclosure to certain persons or institutions of medical or personal information about a client without his or her consent.

**Co-occurring Disorders**—Condition in which a person has more than one disorder or disease.

**Countertransference**—Process of counselors seeing themselves in their clients, overidentifying with their clients, meeting their own personal needs through clients, or reacting to a client because of unresolved personal conflicts.

**Cultural Competence**—Broad-based and diverse understanding of, and ability to respond and relate to, culturally specific nuances, communication styles, traditions, icons, experiences, and spiritual traditions of a given culture or cultures.

**Denigrate**—To cast aspersions on, to defame, or to deny the importance or validity of something or someone.

**Dysphoria**—State of feeling unwell or unhappy.

**Epidemiology**—Incidence, distribution, and control of disease in a population.

**Family of Choice**—Persons an individual sees as significant in his or her life. It may include none, all, or some members of his or her family of origin. In addition, it may include individuals such as significant others or partners, friends, coworkers, etc.
Family of Origin—Birth or biological family or any family system instrumental or significant in an individual’s early development.

Gender Identity—Sense of oneself as male or female. As a comparison, a person may be born biologically male yet have a female gender identity.

Hermaphrodite—A person born with both male and female reproductive organs.

Heterosexism—Value and belief that heterosexuality is the only “natural” sexuality and that it is inherently healthier than or superior to other types of sexuality. Heterosexism is the ideological system that denies, denigrates, and stigmatizes any nonheterosexual form of behavior, identity, relationship, or community.

Heterosexuals—Term used to describe those individuals with a primary sexual and affectional orientation toward persons of the opposite gender. Heterosexuals are often referred to as straight.

Holistic—Consideration of the entire individual (physical, intellectual, emotional, spiritual, and environmental).

Homophobia—Irrational fear or dislike of homosexuals. This includes the discomfort and dislike that some heterosexuals have toward lesbian, gay, bisexual, and transgender individuals.

Homosexual—Term used to describe an individual with a primary sexual and affectional orientation toward persons of the same gender. Male homosexuals are often referred to as gay, whereas female homosexuals are referred to as lesbians.

Internalized Homophobia—Accepting and believing the negative messages of the dominant group as they relate to gay men and lesbians; the internalized self-hatred that gays and lesbians struggle with as a result of heterosexual prejudice.

Life Cycle—Stages of development (infancy, childhood, adolescence, young adult, adult, elder).

Lookism—Prejudice that some people harbor based on a limited and narrow definition of what physical traits are desirable.

Methamphetamine—Powerful central nervous system stimulant. A synthetic drug that has a high potential for abuse and dependence. It is illegally produced and sold in pill form, capsules, powder, and chunks. Methamphetamine was developed early in this century from its parent drug amphetamine and was originally used in nasal decongestants, bronchial inhalers, and the treatment of narcolepsy and obesity. In the 1970s, methamphetamine was classified a Schedule II drug—a drug with little medical use and a high potential for abuse.

Next of Kin—Person or persons designated in case of emergency. Traditionally this designation has been used only for immediate family of origin or married partners.

Nonoperative—The status of a transsexual individual who will not undergo sex reassignment surgery. Also called non-op.

Out or Out of the Closet—Refers to varying degrees of being open about one’s homosexual or bisexual orientation.

Passive Partner—Term frequently used in reference to male-to-male sexual behavior, specifically the receptive partner during sexual intercourse.

Postoperative Person—Transsexual who has completed gender reassignment surgery.

Power of Attorney—Legal document in which one person authorizes another person to act on the former’s behalf.
Preoperative Person—Transsexual who is contemplating gender reassignment surgery.

Quality Improvement Program—A systematic effort undertaken by an organization to analyze processes and procedures and identify and implement changes in order to achieve more desirable outcomes.

Rave—Type of dance party at which many of the patrons are involved in substance use and abuse.

Ryan White Care Act—Federal legislation that authorizes funding for the support of people with HIV/AIDS.

Seropositive—Serotype that suggests someone has experienced infection in the past.

Sex Industry Workers—Individuals (either male or female) who work as prostitutes, hustlers, or escorts and are in the business of providing sex for money, drugs, or housing.

Sexual Harassment—An illegal act that occurs in a place of employment when one person inflicts on another conversations or actions of a sexual nature. This behavior can either involve the condition of concrete employment benefits for sexual favors or create a hostile or offensive working environment for those involved and can be grounds for legal recourse.

Sexual Identity or Orientation—The erotic, physical, and emotional attraction to members of one’s own gender, the opposite gender, or both genders and one’s conscious or subconscious decision to define and label this affinity and attraction.

Significant Other—A life partner, domestic partner, lover, boyfriend, or girlfriend. Because gays and lesbians still are not allowed to be legally married in the United States (although they are allowed to in some European countries), significant other is equivalent to the term “spouse.”

Sodomy Laws—State statutes (which vary by State) that prohibit contact between the mouth or anus of one person and the sexual organs of another person (consensually or otherwise).

Synthesis—Combining of often diverse conceptions into a coherent whole.

Transference—Redirection of feelings and desires.

Transgender Person—One whose gender identity is not congruent with his or her biological gender, regardless of the status of surgical and hormonal gender reassignment processes. Sometimes used as an umbrella term encompassing transsexuals, transvestites, cross dressers, and others. The term transgender refers to a continuum of gender expressions, identities, and roles, which expand the current dominant cultural values of what it means to be female or male.

Transphobia—Irrational fear or dislike of transgender individuals.

Transsexual—Individual with biological characteristics of one sex who identifies himself or herself as the opposite gender. There are female-to-male and male-to-female transsexuals: Transsexuals usually desire to change their bodies to fit their gender identities and do this through hormone treatment and gender reassignment surgery.

Treatment Readiness—Stage or phase that an individual may be in related to changing alcohol and drug use activities (i.e., decrease harmful alcohol- and drug-related behaviors).
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Appendix B–References


<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
</tr>
<tr>
<td>ACLU</td>
<td>American Civil Liberties Union</td>
</tr>
<tr>
<td>ACOA</td>
<td>Adult Children of Alcoholics</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>ADM</td>
<td>alcohol, drug abuse, and mental health</td>
</tr>
<tr>
<td>AFSCME</td>
<td>American Federation of State, County, and Municipal Employees</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>AMBHA</td>
<td>American Managed Behavioral Healthcare Association</td>
</tr>
<tr>
<td>APA</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>API</td>
<td>Asian/Pacific Islanders</td>
</tr>
<tr>
<td>ASI</td>
<td>Addiction Severity Index</td>
</tr>
<tr>
<td>CARF</td>
<td>The Rehabilitation Accreditation Commission</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CEU</td>
<td>continuing education unit</td>
</tr>
<tr>
<td>CMA</td>
<td>crystal methamphetamine</td>
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<tr>
<td>CSAP</td>
<td>Center for Substance Abuse Prevention</td>
</tr>
<tr>
<td>CSAT</td>
<td>Center for Substance Abuse Treatment</td>
</tr>
<tr>
<td>DSM</td>
<td><em>Diagnostic and Statistical Manual of Mental Disorders</em></td>
</tr>
<tr>
<td>EAP</td>
<td>employee assistance program</td>
</tr>
<tr>
<td>ERISA</td>
<td>Employment Retirement Income Security Act</td>
</tr>
<tr>
<td>FFS</td>
<td>fee-for-service</td>
</tr>
<tr>
<td>FTM</td>
<td>female-to-male</td>
</tr>
<tr>
<td>GHB</td>
<td>gamma hydroxybuturate</td>
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<tr>
<td>GID</td>
<td>gender identity disorder</td>
</tr>
<tr>
<td>GLMA</td>
<td>Gay and Lesbian Medical Association</td>
</tr>
<tr>
<td>HEDIS</td>
<td>Health Plan Employer Data and Information Set</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>HMO</td>
<td>health maintenance organization</td>
</tr>
<tr>
<td>IDU</td>
<td>injection drug user/intravenous drug user</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>IPA</td>
<td>Individual Practice Association</td>
</tr>
<tr>
<td>ITA</td>
<td>It's Time America!</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>JAMA</td>
<td><em>Journal of the American Medical Association</em></td>
</tr>
<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations</td>
</tr>
<tr>
<td>LGBT</td>
<td>lesbian, gay, bisexual, and transgender</td>
</tr>
<tr>
<td>LHWN</td>
<td>Lesbian Health and Wellness Network</td>
</tr>
<tr>
<td>MAP</td>
<td>member assistance program</td>
</tr>
<tr>
<td>MAST</td>
<td>Michigan Alcohol Screening Test</td>
</tr>
<tr>
<td>MBHC</td>
<td>managed behavioral health care</td>
</tr>
<tr>
<td>MBHCO</td>
<td>managed behavioral health care organization</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>---------</td>
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<tr>
<td>MCO</td>
<td>managed care organization</td>
</tr>
<tr>
<td>MSM</td>
<td>men who have sex with men</td>
</tr>
<tr>
<td>MTF</td>
<td>male-to-female</td>
</tr>
<tr>
<td>NA</td>
<td>Narcotics Anonymous</td>
</tr>
<tr>
<td>NAADAC</td>
<td>National Association of Alcohol and Drug Abuse Counselors</td>
</tr>
<tr>
<td>NALGAP</td>
<td>National Association of Lesbian and Gay Addiction Professionals</td>
</tr>
<tr>
<td>NASW</td>
<td>National Association of Social Workers</td>
</tr>
<tr>
<td>NCQA</td>
<td>National Committee for Quality Assurance</td>
</tr>
<tr>
<td>NGLTF</td>
<td>National Gay and Lesbian Task Force</td>
</tr>
<tr>
<td>NHSDA</td>
<td>National Household Survey on Drug Abuse</td>
</tr>
<tr>
<td>NIDA</td>
<td>National Institute on Drug Abuse</td>
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<tr>
<td>OAS</td>
<td>Office of Applied Studies</td>
</tr>
<tr>
<td>ONDCP</td>
<td>Office of National Drug Control Policy</td>
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<tr>
<td>PAWS</td>
<td>postacute withdrawal syndrome</td>
</tr>
<tr>
<td>PCCM</td>
<td>primary care case management</td>
</tr>
<tr>
<td>PFLAG</td>
<td>Parents, Families and Friends of Lesbians and Gays</td>
</tr>
<tr>
<td>PHO</td>
<td>physician hospital organization</td>
</tr>
<tr>
<td>PMS</td>
<td>premenstrual syndrome</td>
</tr>
<tr>
<td>POS</td>
<td>point of service</td>
</tr>
<tr>
<td>PPO</td>
<td>preferred provider organization</td>
</tr>
<tr>
<td>PSA</td>
<td>public service announcement</td>
</tr>
<tr>
<td>PSN</td>
<td>provider-sponsored network</td>
</tr>
<tr>
<td>PSO</td>
<td>provider-sponsored organization</td>
</tr>
<tr>
<td>QISMC</td>
<td>quality improvement system for managed care</td>
</tr>
<tr>
<td>RCD</td>
<td>Resource Center of Dallas</td>
</tr>
<tr>
<td>RET</td>
<td>rational-emotive therapy</td>
</tr>
<tr>
<td>ROTC</td>
<td>Reserve Officers’ Training Corps</td>
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<tr>
<td>RWJF</td>
<td>Robert Wood Johnson Foundation</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<tr>
<td>SASSI</td>
<td>Substance Abuse Subtle Screening Inventory</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>TAP</td>
<td>Technical Assistance Publication</td>
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<tr>
<td>TIP</td>
<td>Treatment Improvement Protocol</td>
</tr>
<tr>
<td>WWATS</td>
<td>Whitman-Walker Clinic, Inc., Addiction Treatment Services</td>
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</tbody>
</table>
### Appendix D

#### Studies on LGBT Substance Abuse

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Population</th>
<th>Substance Use/Abuse</th>
<th>Methodology</th>
<th>Comparison Group</th>
<th>Outcome</th>
<th>Comments on Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saghir et al., 1970¹</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>33% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
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<tr>
<td></td>
<td>N=200</td>
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<tr>
<td>Fifield et al., 1977¹</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>35% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
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<td>N=57</td>
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<tr>
<td>Lewis et al., 1982¹</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>28% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
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<tr>
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<td>N=57</td>
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<tr>
<td>Morales &amp; Graves, 1983¹</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>None</td>
<td>27% reported having a problem with alcohol</td>
<td>No comparisons can be made at this time</td>
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<tr>
<td></td>
<td>N=129</td>
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<tr>
<td>Bradford &amp; Ryan, 1987¹</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Population-based (National Lesbian Health Care Survey)</td>
<td>None</td>
<td>6%—daily drinkers 25%—drink 1+/wk 30%—drink1+/mo 17%—abstainers</td>
<td>No comparisons can be made at this time</td>
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<tr>
<td></td>
<td>N=1,917</td>
<td></td>
<td></td>
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<tr>
<td>Stall &amp; Wiley, 1986</td>
<td>Gay men</td>
<td>Alcohol &amp; drugs</td>
<td>Population-based (San Francisco Men's Health Study)</td>
<td>None</td>
<td></td>
<td>Gay men had greater substance use (excluding alcohol) than heterosexual men</td>
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<tr>
<td>McKirnan &amp; Peterson, 1989¹</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>General population women (Clark &amp; Midinak, 1992¹)</td>
<td>76% vs. 59%—Moderate 9% vs. 7%—Heavy 23% vs. 8%—Problems</td>
<td>Lesbians had greater alcohol use than general population women</td>
</tr>
<tr>
<td></td>
<td>N=748</td>
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<td>Bloomfield, 1993¹</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>Heterosexual women (N=397)</td>
<td>69% vs. 74%—Moderate 11% vs. 10%—Heavy 13% vs. 3%—In recovery 20% vs. 16%—Abstainers</td>
<td>Lesbians had greater alcohol use than heterosexual women</td>
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<tr>
<td></td>
<td>N=58</td>
<td></td>
<td></td>
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<tr>
<td>Study</td>
<td>Study Population</td>
<td>Substance Use/Abuse</td>
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<tr>
<td>Skinner, 1994</td>
<td>Lesbians &amp; gay men</td>
<td>Alcohol, cigarettes, marijuana &amp; other illegal drugs</td>
<td>Convenience sample</td>
<td>Heterosexuals</td>
<td>Lesbians &amp; gay men had greater substance use than heterosexuals</td>
<td></td>
</tr>
<tr>
<td>Skinner &amp; Otis, 1996</td>
<td>Lesbians</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>General population women</td>
<td>32% vs. 28%—1-4 drinks/mo</td>
<td>Lesbians used more alcohol than general population women</td>
</tr>
<tr>
<td>Otis, 1996</td>
<td>N=500 sample women</td>
<td>Alcohol</td>
<td>Convenience sample</td>
<td>General population women</td>
<td>26% vs. 11%—5-19 drinks/mo</td>
<td></td>
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<tr>
<td>Hughes et al., 1997</td>
<td>Lesbians</td>
<td>Alcohol or drug problems</td>
<td>Convenience sample</td>
<td>Heterosexual women</td>
<td>10% vs. 2%—2%—5-19 drinks/mo</td>
<td>Lesbians used more substances than heterosexual women</td>
</tr>
<tr>
<td>Clements et al., 1998</td>
<td>Transgender persons (N=515)</td>
<td>Intravenous drug use</td>
<td>Convenience sample</td>
<td>None</td>
<td>34% MTF w/lifetime IV drug use</td>
<td>No comparisons can be made at this time</td>
</tr>
<tr>
<td>Woody et al., 1999</td>
<td>Men who have sex with men (MSM) and are at specific risk for HIV/AIDS (N=3,212)</td>
<td>Alcohol, nitrite inhalants, hallucinogens, stimulants, sedatives, tranquilizers, marijuana, cocaine</td>
<td>Convenience sample</td>
<td>General population men</td>
<td>This nongeneral sample of MSM who were specifically at risk for contracting HIV disease was 21 times more likely to use nitrite inhalants, 6 times more likely to use hallucinogens, 4 times more likely to use stimulants, 7 times more likely to use sedatives, and 5 times more likely to use tranquilizers</td>
<td>MSM used more substances than general population men</td>
</tr>
<tr>
<td>Cochran &amp; Mays, 2000</td>
<td>Same gender (male) partners (N=98)</td>
<td>Alcohol dependence (DSM–IV) Drug dependence (DSM–IV)</td>
<td>Population-based (1996 National Household Survey of Drug Abuse)</td>
<td>Opposite-gender (female) partner(s) only (N=3,922) Opposite-gender (male) partner(s) only (N=5,792)</td>
<td>10% of males with partners of the same gender vs. 7.6% of males with partners of the opposite gender exhibited symptoms of alcohol dependence. 7% of females with partners of the same gender vs. 2% of females with partners of the opposite gender exhibited symptoms of alcohol dependence. 5.7% of males with partners of the same gender vs. 2.8% of males with partners of the opposite gender exhibited symptoms of drug dependence. 5% of females with partners of the same gender vs. 1.3% of females with partners of the opposite gender exhibited symptoms of drug dependence.</td>
<td>Same-sex partners used more substances than opposite-sex partners</td>
</tr>
<tr>
<td>Study</td>
<td>Study Population</td>
<td>Substance Use/Abuse</td>
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<tr>
<td>Cochran et al., in press</td>
<td>Same gender partners (gay and lesbian) (N=194) Opposite gender partners (N=9,714)</td>
<td>Alcohol dependence (DSM-IV)</td>
<td>Population-based (1996 National Household Survey of Drug Abuse)</td>
<td>Same gender partner (male) vs. opposite gender partners (male) Same gender partner (female) vs. opposite gender partners (female)</td>
<td>Lesbians were 2 times more likely to use alcohol in the past month, 3.5 time more likely in the past year, 5 times more likely to use alcohol every day, 2.25 times more likely to get intoxicated, and 4 times more likely than heterosexual women to get intoxicated weekly. There were no differences between gay and straight men.</td>
<td>Lesbians were at higher risk for alcohol use than heterosexual women</td>
</tr>
<tr>
<td>Welch, Howden-Chapman &amp; Collings, 1998</td>
<td>New Zealand lesbians N=200</td>
<td>Drugs</td>
<td>Survey</td>
<td>None</td>
<td>76% reported using cannabis once (lifetime) and 33% reported use in the last year 31% used recreational drugs other than alcohol and cannabis at some time, and 4.5% reported past year use</td>
<td>No comparisons can be made at this time</td>
</tr>
</tbody>
</table>

1As cited in Hughes, T. (November 1999). Sexual Identity and Alcohol Use: A Comparison of Lesbians’ and Heterosexual Women’s Patterns of Drinking. Presentation conducted at the National Institute of Mental Health.